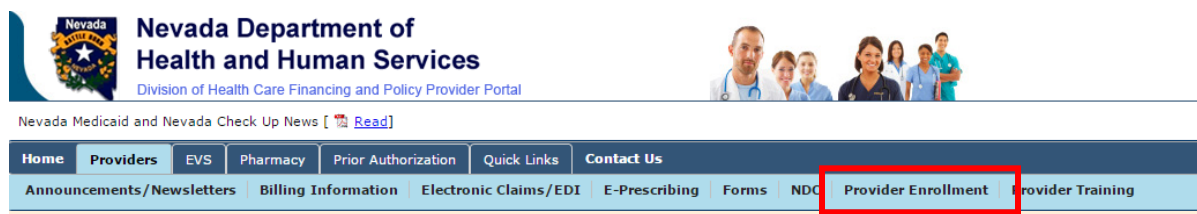


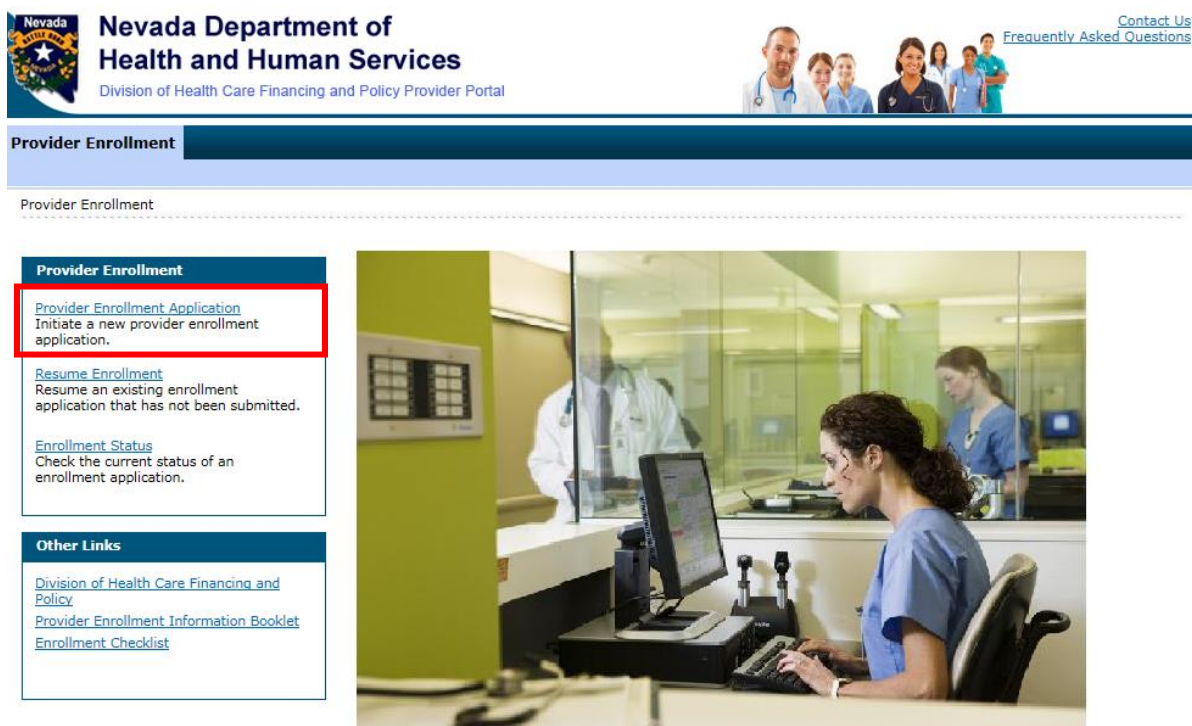
Chapter 2. Initial Enrollment Application

To begin the Online Provider Enrollment Application:


1. On the Nevada Medicaid and Nevada Check Up Health Care content site home page, www.medicaid.nv.gov, click the "Provider" tab, and select "Provider Enrollment."




2. The Provider Enrollment page is displayed.
3. Click the "Online Provider Enrollment" link.
4. The Online Provider Enrollment Portal Home page opens as shown below. Click **"Provider Enrollment Application"** to initiate a new provider enrollment application.



5. The Online Provider Enrollment Welcome page will be displayed. Click **"Continue"** to begin the online application process or click **"Cancel"** to return to the Online Provider Enrollment Portal Home page.



Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Provider Portal



[Contact Us](#)
[Frequently Asked Questions](#)

Provider Enrollment[Provider Enrollment](#) > Provider Enrollment Application

Provider Enrollment: Welcome

Welcome

Request Information

Specialties

Addresses

Provider Identification

Other Information

Managing Individuals

Agreement

Attachments

Summary

Welcome to the Online Provider Enrollment System

Thank you for your interest in the Nevada Medicaid and Nevada Check Up Program. To bill for services rendered to Nevada Medicaid recipients, you must enroll with Hewlett Packard Enterprise as a Nevada Medicaid Provider. Hewlett Packard Enterprise is the current fiscal agent for the Nevada Medicaid and Nevada Check Up program.

All of the materials within this document must be completed and submitted to Hewlett Packard Enterprise for your request to be processed. A [checklist](#) of required documentation has been provided for your convenience. Please review the [Provider Information Enrollment Booklet](#) for additional information.

Submission of incomplete materials will delay your request. In addition to required documentation, additional supporting documentation can be uploaded with your application if necessary. If your responses to any questions on this enrollment application did not fit into the field on the page, type the question and response and upload the documentation using Other as the attachment type on the Attachments page of this online application. All documents must be uploaded at the time of provider enrollment forms submission in order for your application to be considered complete. Please retain copies of your materials for your records. You will receive written notification upon approval or denial of your request.

If you have questions concerning enrollment, contact Provider Enrollment at (877) 638-3472 (select options for "Provider Enrollment") between 8:00 a.m. and 5:00 p.m., Monday through Friday.

Please click the **"Continue"** to proceed.

Continue

Cancel

2.1. Request Information

To begin the provider enrollment process, complete the required fields on the Request Information page. Once the required fields have been completed, click **“Continue”** to go on to the next page, or click **“Finish Later”** to save your application and finish it at a later date. All fields with a red asterisk (*) are required. The fields that are displayed throughout the enrollment process are contingent on the Enrollment Type or Provider Type values selected.

[Provider Enrollment](#) > Enrollment Request Information

Provider Enrollment: Request Information	
Welcome	Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later".
Request Information	The contact person will potentially be contacted to answer any questions regarding the information provided in this request.
Specialties	* Indicates a required field.
Addresses	
Provider Identification	Initial Enrollment Information
Other Information	*Enrollment Type <input type="text"/>
Attachments and Fees	*Provider Type <input type="text"/>
Agreement	*Requested Enrollment Effective Date <input type="text" value="08/31/2015"/>
Summary	Provider Information
	*Are you currently enrolled as a Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No
	*Were you previously enrolled as a Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No
	Contact Information
	This contact information is required for correspondence regarding the associated application. Provide the appropriate contact person and information who can assist with the request.
	*Last Name <input type="text"/>
	*First Name <input type="text"/>
	*Telephone Number <input type="text"/> Telephone Number Extension <input type="text"/>
	Fax Number <input type="text"/>
	*Contact Email <input type="text"/>
	*Confirm Email Address <input type="text"/>
	*Preferred Method of Communication <input type="text" value="Email"/>
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>

Initial Enrollment Information:

[Provider Enrollment](#) > Enrollment Request Information

Provider Enrollment: Request Information	
Welcome	Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later".
Request Information	The contact person will potentially be contacted to answer any questions regarding the information provided in this request. * Indicates a required field.
Specialties	
Addresses	Initial Enrollment Information
Provider Identification	1 *Enrollment Type <input type="text"/>
Other Information	2 *Provider Type <input type="text"/>
Attachments and Fees	
Agreement	3 *Requested Enrollment Effective Date 08/31/2015 <input type="text"/>

1. **Enrollment Type** – Select the type of enrollment from the dropdown list.

Provider Enrollment: Request Information	
Welcome	Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later".
Request Information	The contact person will potentially be contacted to answer any questions regarding the information provided in this request. * Indicates a required field.
Specialties	
Addresses	Initial Enrollment Information
Provider Identification	*Enrollment Type <input type="text"/>
Other Information	*Provider Type <input type="text"/>
Attachments and Fees	
Agreement	*Requested Enrollment Effective Date 08/31/2015 <input type="text"/>

Note:

Ordering, Prescribing or Referring (OPR) providers are not fully enrolled as Nevada Medicaid providers and cannot seek reimbursement for services rendered to Medicaid recipients or submit claims to Nevada Medicaid.

2. **Provider Type** – Select the appropriate 2-digit provider type from the dropdown list. Some providers provide more than one type of service. You must complete one complete application for each provider type you are enrolling. For example, if you supply Durable Medical Equipment (provider type 33) as well as pharmaceutical drugs (provider type 28), complete two enrollment applications.

Group Enrollment Type

Initial Enrollment Information	
*Enrollment Type	Group
Ownership change	<input type="checkbox"/>
*Provider Type	<div> 10-OUTPATIENT SURGERY,HOSP BASED 11-HOSPITAL, INPATIENT 12-HOSPITAL,OUTPATIENT 13-PSYCHIATRIC HOSP,INPATIENT 14-MENTAL HEALTH OUTPATIENT SERV 16-ICF-MR / PUBLIC 17-SPECIAL CLINICS 19-NURSING FACILITY 20-PHYSICIAN,M.D.,OSTEOPATH 21-PODIATRIST 22-DENTIST 23-HEARING AID DISPENSER/RELTD 24-CERTIFIED R.N. PRACTITIONER 25-OPTOMETRIST 26-PSYCHOLOGIST 27-RADIOLOGY/NONINVASIVE DIAG CTR 28-PHARMACY 29-HOME HEALTH AGENCY 30-PERSONAL CARE AID-PROV AGENCY 32-AMBULANCE,AIR/GROUND 33-DME, DISPOSABLE, PROSTHETICS 34-THERAPY 36-CHIROPRACTOR 37-INTRAVENOUS THERAPY 38-HOME/COMM BASED WAIVER-MR 39-ADULT DAY HEALTH CENTER 41-OPTICIAN,OPTICAL BUSINESS 42-OUTPATIENT PSYCH HOSP.,PRIVATE 43-LABORATORY,PATHOLOGY/CLINICAL </div>
*Requested Enrollment Effective Date	
Provider Information	
A Federal Tax Identification Number, also known as	identify a business entity.
*Federal Tax ID	
*Are you currently enrolled as a Provider	
*Were you previously enrolled as a Provider	
Contact Information	
This contact information is required for correspondence information who can assist with the request.	appropriate contact person and
*Last Name	
*First Name	

Individual Enrollment Type

Initial Enrollment Information	
*Enrollment Type	Individual
Ownership change	<input type="checkbox"/>
Electronic Health Records (EHR)	<input type="checkbox"/>
*Provider Type	<div> 14-MENTAL HEALTH OUTPATIENT SERV 20-PHYSICIAN,M.D.,OSTEOPATH 21-PODIATRIST 22-DENTIST 23-HEARING AID DISPENSER/RELTD 24-CERTIFIED R.N. PRACTITIONER 25-OPTOMETRIST 26-PSYCHOLOGIST 34-THERAPY 36-CHIROPRACTOR 38-HOME/COMM BASED WAIVER-MR 41-OPTICIAN,OPTICAL BUSINESS 48-SENIOR WAIVER(FRAIL ELDERLY) 58-PHYSICALLY DISABLED WAIVER 72-NURSE ANESTHETIST 74-NURSE MIDWIFE 76-AUDIOLOGIST 77-PHYSICIANS ASSISTANT 82-MH REHABILITATIVE TREATMENT 85-APPLIED BEHAVIOUR ANALYSIS PROVIDER </div>
*Requested Enrollment Effective Date	
Provider Information	
A Federal Tax Identification Number, also known as	identify a business entity.
Federal Tax ID	
*SSN	
*Are you currently enrolled as a Provider	
*Were you previously enrolled as a Provider	
Contact Information	

OPR Enrollment Type

Initial Enrollment Information	
*Enrollment Type	Ordering, Prescribing or Referring
*Provider Type	<div> 14-MENTAL HEALTH OUTPATIENT SERV 20-PHYSICIAN,M.D.,OSTEOPATH 21-PODIATRIST 22-DENTIST 23-HEARING AID DISPENSER/RELTD 24-CERTIFIED R.N. PRACTITIONER 25-OPTOMETRIST 26-PSYCHOLOGIST 34-THERAPY 38-HOME/COMM BASED WAIVER-MR 41-OPTICIAN,OPTICAL BUSINESS 48-SENIOR WAIVER(FRAIL ELDERLY) 58-PHYSICALLY DISABLED WAIVER 72-NURSE ANESTHETIST 74-NURSE MIDWIFE 76-AUDIOLOGIST 77-PHYSICIANS ASSISTANT 82-MH REHABILITATIVE TREATMENT </div>
*Requested Enrollment Effective Date	
OPR Information	
Please check the appropriate boxes explaining why	
<input type="checkbox"/> Reimbursement Rates <input type="checkbox"/> Medicaid Policy <input type="checkbox"/> Practice Capacity <input type="checkbox"/> Other	
Provider Information	

Note: If, after initially updating the initial enrollment information, either the Enrollment Type or the Provider Type fields in the Request Information page are subsequently changed prior to submitting the final enrollment request, you must navigate back through the entire enrollment application. Fields that are contingent on the Enrollment Type or Provider Type values are reset to blank and must be re-entered. You must respond to a confirmation dialog prior to changing the Provider Type value.

3. **Effective Date** – Enter the date on which you wish the provider enrollment to begin. The date in this field cannot be a future date. The date can be backdated up to six months, but may not be prior to all provider enrollment requirements being met. To exceed the six-month back limitation, provide a written explanation and supporting documentation as an attachment to this application.

If you have already provided services, review the dates of service you will be billing and enter a date that will cover all of your back billing. If you have no back billing, enter the current date. Timely filing limits apply. (Timely Filing Limits: From the Date of Service or the recipient's date of eligibility, whichever is later, you have 180 days to submit in-state provider claims when Medicaid is the only insurance or 365 days to submit out-of-state provider claims and claims when the recipient has a primary health insurance carrier other than Medicaid.)

Provider Enrollment: Request Information	
Welcome	Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later".
Request Information	The contact person will potentially be contacted to answer any questions regarding the information provided in this request.
Specialties	* Indicates a required field.
Addresses	
Provider Identification	
Other Information	
Managing Individuals	
Agreement	
Initial Enrollment Information	
*Enrollment Type	
*Provider Type	
*Requested Enrollment Effective Date	09/18/2015

Group Association:

When Individual Enrollment Type and Provider Type 14, 20, 21, 22, 24, 25, 26, 34, 36, 72, 74, 76, 77 or 82 is selected from the dropdown lists, the required fields on the Group Association Panel will need to be completed.

- Select “Yes” if you would like to be linked to a group.
- Select “No” if you do not want to be linked to a group.

If you select “Yes” you would like to be linked to a group, enter the group’s National Provider Identifier (NPI) and the date you would like to be affiliated with the group. You may enter a date in the past. Please note that timely filing limits apply. When the group’s NPI is used as the billing provider on a claim, payments will be made to the Provider Group.

Group Enrollment is required for provider types 14 and 82.

Initial Enrollment Information		
*Enrollment Type	Individual	
Ownership change	<input type="checkbox"/>	
Electronic Health Records (EHR)	<input type="checkbox"/>	
*Provider Type	20-PHYSICIAN,M.D.,OSTEOPATH	
*Requested Enrollment Effective Date	08/31/2015	
Group Association		
To become affiliated or remain with an existing Medicaid Provider Group, enter the Group’s NPI and the date to begin the affiliation. Otherwise, leave this field blank. This is required for provider types 14 and 82.		
Would You Like to be Linked to a Group? <input checked="" type="radio"/> Yes <input type="radio"/> No		
Group NPI		
Affiliation Begin Date		
Action		
<input type="checkbox"/>		
*NPI	1234567890	
*Affiliation Begin Date	08/31/2015	
<input type="button" value="Add"/> <input type="button" value="Cancel"/>		

Note: Provider Type 14 with specialty 305, 306 or 307 do not have to be linked to a group.

Initial Enrollment Information	
*Enrollment Type	Individual
Ownership change	<input type="checkbox"/>
Electronic Health Records (EHR)	<input type="checkbox"/>
*Provider Type	14-MENTAL HEALTH OUTPATIENT SERV
*Requested Enrollment Effective Date	09/02/2015
Group Association	
To become affiliated or remain with an existing Medicaid Provider Group, enter the Group's NPI and the date to begin the affiliation. Otherwise, leave this field blank. This is required for provider types 14 and 82.	
*Are you PT 014 with Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, or Licensed Clinical Professional specialty?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Would You Like to be Linked to a Group?	<input type="radio"/> Yes <input checked="" type="radio"/> No

OPR Information:

If the Ordering, Prescribing, or Referring (OPR) provider type is selected, the OPR Panel will be displayed. You will be required to check the appropriate boxes explaining why you do not wish to be a fully enrolled Nevada Medicaid provider.

Provider Enrollment: Request Information	
Welcome	Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later".
Request Information	The contact person will potentially be contacted to answer any questions regarding the information provided in this request.
Specialties	* Indicates a required field.
Addresses	
Provider Identification	
Other Information	
Attachments and Fees	
Agreement	
Summary	
Initial Enrollment Information	
*Enrollment Type	Ordering, Prescribing or Referring
*Provider Type	20-PHYSICIAN,M.D.,OSTEOPATH
*Requested Enrollment Effective Date	08/31/2015
OPR Information	
Please check the appropriate boxes explaining why you do not wish to be a fully enrolled Nevada Medicaid provider.	
<input type="checkbox"/> Reimbursement Rates <input type="checkbox"/> Medicaid Policy <input type="checkbox"/> Practice Capacity <input type="checkbox"/> Other	

Provider Information:

The information displayed on the Provider Information section will depend on the enrollment type selected. See below for the required fields based on enrollment type.

Group Enrollment Type

For group enrollment type the following fields are displayed:

1. Federal Tax ID – For group enrollment type this is a required field.
2. Are you currently enrolled as a Provider? – This is a required question, select the “Yes” or “No” radio button.
3. Were you previously enrolled as a Provider? – This is a required question, select the “Yes” or “No” radio button.

Provider Information	
A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.	
1	*Federal Tax ID <input type="text"/>
2	*Are you currently enrolled as a Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No
3	*Were you previously enrolled as a Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No

Individual Enrollment Type

For individual enrollment type the following fields are displayed:

1. Federal Tax ID – For individual enrollment type this is an optional field.
2. Social Security Number (SSN) – For individual enrollment type this is a required field.
3. Are you currently enrolled as a Provider? – This is a required question, select the “Yes” or “No” radio button.
4. Were you previously enrolled as a Provider? – This is a required question, select the “Yes” or “No” radio button.

Provider Information	
A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.	
1	Federal Tax ID <input type="text"/>
2	*SSN <input type="text"/>
3	*Are you currently enrolled as a Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No
4	*Were you previously enrolled as a Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No

Note: For Individual and Group enrollment types the legal name and Tax Identification Number or Social Security Number listed must match the information registered with the Internal Revenue Service (IRS), what is listed on your IRS Employer ID Number (EIN) confirmation letter and the W-9 form. A copy of your IRS acceptance letter will need to be included as an attachment to your online provider enrollment application.

OPR Enrollment Type

For OPR enrollment type the following fields are displayed:

1. Social Security Number (SSN) – For OPR enrollment type this is a required field.

Provider Information
A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
<div><div>1</div><div>*SSN ⓘ</div><div><input type="text" value="-- -- --"/></div><div>x</div></div>

Contact Information:

The contact information is required for correspondence regarding the associated application. Provide the appropriate contact person and information who can assist with the request.

Contact Information

This contact information is required for correspondence regarding the associated application. Provide the appropriate contact person and information who can assist with the request.

1

*Last Name

2

*First Name

3

*Telephone Number

4

Telephone Number Extension

5

Fax Number

6

*Contact Email

7

*Confirm Email Address

8

*Preferred Method of Communication

Email

▼

Continue

Finish Later

Cancel

1. Last Name – Enter the contact person's last name.
2. First Name – Enter the contact person's first name.
3. Telephone Number – Enter the contact person's telephone number.
4. Telephone Number Extension – Enter the contact person's extension if applicable.
5. Fax Number – Enter the contact person's fax number if applicable.
6. Contact Email – Enter the contact person's email.
7. Confirm Email Address – Re-enter the contact person's email.
8. Preferred Method of Communication – Select the preferred method of communication from the drop-down list.

Once the required fields have been completed, click **"Continue"** to go on to the next page or click **"Finish Later"** to save your application and finish it at a later date or **"Cancel"** to return to the Online Provider Enrollment Portal Home page.

2.2. Specialties

The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on the specialties screen. Only one specialty can be designated as the primary specialty. See the Provider Enrollment Information Booklet for the complete list of provider types and specialty codes.

A specialty is required for provider types 14, 17, 19, 20, 34, 38, 48, 57, 58 and 82.

To assist in Medicaid tracking, we recommend that provider types 22, 26, 54 and 76 identify a specialty when applicable.

If a provider does not have a specialty, please enter NO SPECIALTY.

Specialties

The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on this screen. Only one specialty can be designated as the primary specialty. See the [Provider Enrollment Information Booklet](#) for the complete list of provider types and specialty codes. If a provider does not have a specialty, please enter the specialty NO SPECIALTY. You can also enter an optional board certification for each specialty.

* Indicates a required field.
✓ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click the **Remove** link to remove the entire row.

Specialty	Action
Click to collapse.	
Provider Type OPTOMETRIST	
1 *Specialty	
2 Specialty Code _ Primary	✓
3 Specialty Board	
4 Add Reset	

Continue Finish Later Cancel

1. Specialty – Select the provider's specialty from the drop-down list.
2. Primary – Use the checkbox to indicate whether the selected specialty is the primary specialty for this provider.
Note: The first specialty selected will default to the primary specialty.
3. Specialty Board – Enter the Specialty Board Name (Optional).
4. Click **"Add"** to add the specialty information.
5. Click the '+' on a new line to add another specialty. Repeat steps 1 through 4 to add more specialties.

Specialties

The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on this screen. Only one specialty can be designated as the primary specialty. See the [Provider Enrollment Information Booklet](#) for the complete list of provider types and specialty codes. If a provider does not have a specialty, please enter 000 - NO SPECIALTY. You can also enter an optional board certification for each specialty.

* Indicates a required field.

✓ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Collapse the row and click the **"Remove"** link to remove the entire row.

	Specialty	Action
+	✓ PEDIATRICS	
5	+	Click to add specialty.

[Continue](#)

[Finish Later](#)

[Cancel](#)

6. To remove a listed specialty, click the "Remove" link.

Note: You cannot remove the primary specialty. The primary specialty can only be updated by opening the primary specialty row and the saving changes.

* Indicates a required field.

✓ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Collapse the row and click the **"Remove"** link to remove the entire row.

	Specialty	Action
+	✓ PEDIATRICS	
+	PEDIATRIC SURGERY	6 Remove
+	Click to add specialty.	

7

[Continue](#)

[Finish Later](#)

[Cancel](#)

7. Click **"Continue"** to continue the enrollment process. – OR –
Click **"Finish Later"** to save the enrollment application and finish it at a later date.
– OR –
Click **"Cancel"** to cancel the enrollment application.

2.3. Address

Provider addresses identify each location where a provider performs services, as well as locations that are used for billing and payment. An address can be added for each address type.

Individual and Group Enrollment Types

For Individual and Group enrollment types the service address is required, and must be a physical location of the practice/business/facility where services will be rendered. This must be a street address and not a post office box.

Paper checks will be mailed to Pay To address while Electronic Funds Transfer (EFT) testing is performed. If you do not supply a Pay To address, paper checks will be mailed to the service address.

Hewlett Packard Enterprise will mail written correspondence, excluding remittance advices, to the Mail To address. If you do not supply a Mail To address, written correspondence will be mailed to the service address.

Hewlett Packard Enterprise recommends using electronic instead of paper Remittance Advices (RAs) for faster account reconciliation. However, if you wish to receive paper RAs and have them mailed to an address different from the addresses listed above, please complete the "Remittance Advice" address.

Enter each type of valid provider address including location(s) where a provider renders services, as well as location(s) used for billing and payment.

OPR Enrollment Types

For OPR enrollment types, the Mail To and Contact addresses are required. Hewlett Packard Enterprise will mail written correspondence to the Mail To address and attempt to make contact at the phone number provided.

If questions arise during the processing of this Application, Hewlett Packard Enterprise will attempt to contact you directly at the location given in Mail To address. Please designate an alternate contact person in Contact address. NOTE: The Contact Person reported in Contact address will only be authorized to discuss issues concerning this Application. Hewlett Packard Enterprise will not discuss any other enrollment or Medicaid issues about you with the Contact Person listed in Contact address.

Provider Enrollment: Addresses											
Welcome Request Information Specialties Addresses Provider Identification EFT Enrollment Other Information Managing Individuals Agreement Attachments Summary	<p>* Indicates a required field.</p> <p>Provider Addresses</p> <p>The service address is required. The service address is the physical location of the practice/business/facility where services will be rendered. This must be a street address and NOT a post office box.</p> <p>Paper checks will be mailed to Pay-To address while Electronic Funds Transfer (EFT) testing is performed. If you do not supply a Pay-To address, paper checks will be mailed to the service address.</p> <p>Hewlett Packard Enterprise will mail written correspondence, excluding remittance advices, to Mail-To address. If you do not supply a Mail-To address, written correspondence will be mailed to the service address.</p> <p>Hewlett Packard Enterprise recommends using electronic instead of paper Remittance Advices (RAs) for faster account reconciliation. However, if you wish to receive paper RAs and have them mailed to an address different from the addresses listed above, please complete the Remittance Advice address.</p> <p>Enter each type of valid provider address including location(s) where a provider renders services, as well as location(s) used for billing and payment.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Collapse the row and click the "Remove" link to remove the entire row or "Copy" link to copy the entire row.</p> <table border="1"> <thead> <tr> <th>Type</th> <th>Street</th> <th>City</th> <th>State</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="5"> <div>Click to collapse.</div> <div> <div>*Address Type <input type="text"/></div> <div>*Street <input type="text"/></div> <div>*City <input type="text"/></div> <div>*Zip+4 <input type="text"/></div> <div>Email Address <input type="text"/></div> <div> <div>Telephone Number Office <input type="text"/></div> <div>Telephone Number Fax <input type="text"/></div> <div>Telephone Number TDD <input type="text"/></div> </div> <div>Contact Name <input type="text"/></div> <div> <div>Telephone Number Contact <input type="text"/></div> <div>Telephone Number Extension <input type="text"/></div> </div> <div> <div>*State <input type="text"/></div> <div>*County <input type="text"/></div> <div>Confirm Email Address <input type="text"/></div> </div> <div> <div>Add</div> <div>Reset</div> </div> </div> </td> </tr> </tbody> </table>	Type	Street	City	State	Action	<div>Click to collapse.</div> <div> <div>*Address Type <input type="text"/></div> <div>*Street <input type="text"/></div> <div>*City <input type="text"/></div> <div>*Zip+4 <input type="text"/></div> <div>Email Address <input type="text"/></div> <div> <div>Telephone Number Office <input type="text"/></div> <div>Telephone Number Fax <input type="text"/></div> <div>Telephone Number TDD <input type="text"/></div> </div> <div>Contact Name <input type="text"/></div> <div> <div>Telephone Number Contact <input type="text"/></div> <div>Telephone Number Extension <input type="text"/></div> </div> <div> <div>*State <input type="text"/></div> <div>*County <input type="text"/></div> <div>Confirm Email Address <input type="text"/></div> </div> <div> <div>Add</div> <div>Reset</div> </div> </div>				
Type	Street	City	State	Action							
<div>Click to collapse.</div> <div> <div>*Address Type <input type="text"/></div> <div>*Street <input type="text"/></div> <div>*City <input type="text"/></div> <div>*Zip+4 <input type="text"/></div> <div>Email Address <input type="text"/></div> <div> <div>Telephone Number Office <input type="text"/></div> <div>Telephone Number Fax <input type="text"/></div> <div>Telephone Number TDD <input type="text"/></div> </div> <div>Contact Name <input type="text"/></div> <div> <div>Telephone Number Contact <input type="text"/></div> <div>Telephone Number Extension <input type="text"/></div> </div> <div> <div>*State <input type="text"/></div> <div>*County <input type="text"/></div> <div>Confirm Email Address <input type="text"/></div> </div> <div> <div>Add</div> <div>Reset</div> </div> </div>											
<div>Continue</div> <div>Finish Later</div> <div>Cancel</div>											

1. Address Type – Select the correct address type from the drop-down list.

Type	Street	City	State	Action
Click to collapse.				
*Address Type <input type="text"/>	*Street <input type="text"/>	*City <input type="text"/>	*State <input type="text"/>	

2. Enter the required information for the Address Type selected.

3. Click the **"Add"** button to add the address to the address list.

	Type	Street	City	State	Action
<input type="checkbox"/>	Service	123 Main Street	Las Vegas	Nevada	Copy Remove
<input type="checkbox"/>	Click to add address.				

4. To add an additional address to the address list, click the (+) plus sign "Click to add address" and repeat steps 1-3 to add the new address to the address list.

	Type	Street	City	State	Action
<input type="checkbox"/>	Click to collapse.				
	*Address Type <input type="text"/>				
	*Street <input type="text"/>				
	*City <input type="text"/>			*State <input type="text"/>	
	*Zip+4 <input type="text"/>			*County <input type="text"/>	
	Email Address <input type="text"/>	Confirm Email Address <input type="text"/>			
	Telephone Number Office <input type="text"/>	Telephone Number Extension <input type="text"/>			
	Telephone Number Fax <input type="text"/>				
	Telephone Number TDD <input type="text"/>				
	Contact Name <input type="text"/>				
	Telephone Number Contact <input type="text"/>	Telephone Number Extension <input type="text"/>			
	<input type="button" value="Add"/>	<input type="button" value="Reset"/>			

5. Once the maximum number of addresses have been added, the message "You have reached the maximum number of addresses allowed for this list" will appear.

	Type	Street	City	State	Action
<input type="checkbox"/>	Service	123 Main Street Suite A	Las Vegas	Nevada	Remove
<input type="checkbox"/>	Pay-To	123 Main Street Suite B	Las Vegas	Nevada	Remove
<input type="checkbox"/>	Mail-To	123 Main Street Suite B	Las Vegas	Nevada	Remove
<input type="checkbox"/>	Remittance Advice	123 Main Street Suite B	Las Vegas	Nevada	Remove
You have reached the maximum number of addresses allowed for this list.					
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>					

6. Click **"Continue"** to continue the enrollment process. -- OR --
 Click **"Finish Later"** to save the enrollment application and finish it at a later date.
 -- OR --
 Click **"Cancel"** to cancel the enrollment application.

2.4. Provider Identification

The Provider Identification page allows you to enter provider information, such as legal name, business name and any identification numbers, such as tax IDs, License Numbers, CLIA Certification and DEA number.

Group Enrollment Type

Please answer all required questions that are marked with a (*) red asterisk. The following instructions are designed to clarify certain questions. No instructions have been given for questions considered to be self-explanatory.

Provider Enrollment: Provider Identification	
Welcome	* Indicates a required field.
Request Information	Provider Legal Name
Specialties	The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9, and is used by the Nevada Medicaid to generate the annual 1099 form for tax purposes.
Addresses	* Provider Legal Name <input type="text"/>
Provider Identification	Doing Business As Name <input type="text"/>
Associated Providers	Special Ownership Type
EFT Enrollment	Special Ownership Type
Other Information	Special Ownership Type
Managing Individuals	* Is this entity owned or operated by the State of Nevada or any of its political subdivisions, e.g. state agency, county, entity or school district? <input type="radio"/> No <input type="radio"/> Yes
Agreement	Special Ownership Type <input type="text"/>
Attachments	NPI
Summary	The NPI is the National Provider Identifier that is applied for and received through the NPPES Registry for all healthcare providers.
	* NPI <input type="text"/>
	License
	* Name of Issuing Licensing Board, State or Entity <input type="text"/>
	* License Number <input type="text"/> * License State <input type="text"/>
	* Effective Date <input type="text"/> * End Date <input type="text"/>

Business Information			
Nevada Secretary of State Issued Business ID	<input type="text"/>		
Nevada Secretary of State Registered Name	<input type="text"/>		
*Choose the option that most closely describes the entity you are enrolling <input type="text"/>			
CLIA Certification			
CLIA Number	<input type="text"/>		
Drug Enforcement Administration (DEA) Number			
DEA #	<input type="text"/>		
Taxonomy Codes			
Choose your Taxonomy Codes			
#	Taxonomy Codes		
Click to add new Taxonomy Code.			
*Taxonomy Codes	<input type="text"/>		
<input type="button" value="Add"/>	<input type="button" value="Cancel"/>		
Durable Medical Equipment			
List the names and addresses of all manufacturers and suppliers relative to the provision of services, goods, supplies or with whom you have a business relationship merchandise.			
#	Manufacturer or Supplier Name	City	Action
Click to add new Manufacturer/Supplier.			
*Manufacturer or Supplier Name	<input type="text"/>		
*Street	<input type="text"/>		
*City	<input type="text"/>		
*State	<input type="text"/>		
*Zip+4	<input type="text"/>		
*National Clearing House Number	<input type="text"/>		
*Will you bill Medicare Crossovers Claims only? <input checked="" type="radio"/> No <input type="radio"/> Yes			
<input type="button" value="Add"/>	<input type="button" value="Cancel"/>		
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>			

Note: The Durable Medical Equipment panel will only display for Provider Type 33.

Provider Legal Name:

Provider Enrollment: Provider Identification	
Welcome	* Indicates a required field.
Request Information	Provider Legal Name
Specialties	The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9, and is used by the Nevada Medicaid to generate the annual 1099 form for tax purposes.
Addresses	
1 Provider Identification	* Provider Legal Name <input type="text"/>
2 Associated Providers	Doing Business As Name <input type="text"/>

1. Provider Legal Name – The Provider Legal Name listed must match the information registered with the Internal Revenue Service (IRS), what is listed on your IRS Employer ID Number (EIN) confirmation letter and the W-9 form. Include a copy of the IRS acceptance letter with the enrollment application.
2. Doing Business as Name – Enter the Doing Business as Name. (Optional)

Special Ownership Type:

Special Ownership Type	
Other Information	
Managing Individuals	
1 Attachments and Fees	* Is this entity owned or operated by the State of Nevada or any of its political subdivisions, e.g. state agency, county, entity or school district? <input checked="" type="radio"/> No <input type="radio"/> Yes
Agreement	
Summary	
2 Special Ownership Type	<input type="text"/>

1. Is this entity owned or operated by the State of Nevada or any of its political subdivisions, e.g., state agency, county, entity or school district? – Select “No” or “Yes”
2. Special Ownership Type – If the entity has a special ownership type, select the type of ownership from the drop-down list.

Special Ownership Type

County-owned
Government-owned
No owner
Non-Profit
State-owned

Business Information:

Business Information	
1 Nevada Secretary of State Issued Business ID	<input type="text"/>
2 Nevada Secretary of State Registered Name	<input type="text"/>
3 * Choose the option that most closely describes the entity you are enrolling	<input type="text"/>

1. Nevada Secretary of State Issued Business ID – Enter the Secretary of State issued NV Business ID number.
2. Nevada Secretary of State Registered Name – Enter the entity name listed on your business license or registered with the Secretary of State office.
3. Choose the option that most closely describes the entity you are enrolling. – Select the option from the drop-down list.

***Choose the option that most closely describes the entity you are enrolling**

Corporation
Indian Health Program (IHP)
Indian Health Services
Limited Liability Company
Limited Liability Partner
Non-Profit
Partnership
Provider Group
Sole Proprietorship

Individual Enrollment Type

Please answer all required questions that are marked with a (*) red asterisk. The following instructions are designed to clarify certain questions. No instructions have been given for questions considered to be self-explanatory.

Provider Enrollment: Provider Identification													
Welcome	* Indicates a required field.												
Request Information	Provider Legal Name												
Specialties	The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9, and is used by the Nevada Medicaid to generate the annual 1099 form for tax purposes.												
Addresses													
Provider Identification	*Last Name <input type="text"/>												
EFT Enrollment	*First Name <input type="text"/>												
Other Information	Middle <input type="text"/>												
Managing Individuals	Doing Business As Name <input type="text"/>												
Agreement													
Attachments													
Summary													
	Individual Providers												
	*Gender <input type="text"/> *Birth Date <input type="text"/>												
	Special Ownership Type												
	Special Ownership Type <input type="text"/>												
	NPI												
	The NPI is the National Provider Identifier that is applied for and received through the NPPES Registry for all healthcare providers.												
	*NPI <input type="text"/>												
	License												
	*Name of Issuing Licensing Board, State or Entity <input type="text"/>												
	*License Number <input type="text"/> *License State <input type="text"/>												
	*Effective Date <input type="text"/> *End Date <input type="text"/>												
	Business Information												
	Nevada Secretary of State Issued Business ID <input type="text"/> Nevada Secretary of State Registered Name <input type="text"/>												
	*Choose the option that most closely describes the entity you are enrolling <input type="text"/>												
	CLIA Certification												
	CLIA Number <input type="text"/>												
	Drug Enforcement Administration (DEA) Number												
	DEA # <input type="text"/>												
	Taxonomy Codes												
	Choose your Taxonomy Codes												
	<table border="1"><thead><tr><th>#</th><th>Taxonomy Codes</th><th>Action</th></tr></thead><tbody><tr><td colspan="3">Click to add new Taxonomy Code.</td></tr><tr><td colspan="3">*Taxonomy Codes <input type="text"/></td></tr><tr><td colspan="3"><input type="button" value="Add"/> <input type="button" value="Cancel"/></td></tr></tbody></table>	#	Taxonomy Codes	Action	Click to add new Taxonomy Code.			*Taxonomy Codes <input type="text"/>			<input type="button" value="Add"/> <input type="button" value="Cancel"/>		
#	Taxonomy Codes	Action											
Click to add new Taxonomy Code.													
*Taxonomy Codes <input type="text"/>													
<input type="button" value="Add"/> <input type="button" value="Cancel"/>													
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>												

Provider Legal Name:

Provider Enrollment: Provider Identification	
Welcome	* Indicates a required field.
Request Information	Provider Legal Name
Specialties	The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9, and is used by the Nevada Medicaid to generate the annual 1099 form for tax purposes.
Addresses	
Provider Identification	<div>1 *Last Name</div> <div>2 *First Name</div> <div>3 Middle</div> <div>4 Doing Business As Name</div>
EFT Enrollment	
Other Information	
Managing Individuals	
Assessment	

1. Last Name – Enter the provider’s last name.
2. First Name – Enter the provider’s first name.
3. Middle Initial – Enter the provider’s middle initial. (Optional)

The provider’s name listed must match the information registered with the Internal Revenue Service (IRS), what is listed on your IRS Employer ID Number (EIN) confirmation letter and the W-9 form. Include a copy of the IRS acceptance letter with the enrollment application.

4. Doing Business as Name – Enter the Doing Business as Name. (Optional)

Special Ownership Type:

Special Ownership Type	
1	Special Ownership Type <input type="text"/>

1. Special Ownership Type – If the entity has a special ownership type, select the type of ownership from the drop-down list.

Special Ownership Type
County-owned
Government-owned
No owner
Non-Profit
State-owned

Business Information:

Business Information	
1	Nevada Secretary of State Issued Business ID <input type="text"/>
2	Nevada Secretary of State Registered Name <input type="text"/>
3	*Choose the option that most closely describes the entity you are enrolling <input type="text"/>

1. Nevada Secretary of State Issued Business ID – Enter the Secretary of State issued NV Business ID number.
2. Nevada Secretary of State Registered Name – Enter the entity name listed on your business license or registered with the Secretary of State office.
3. Choose the option that most closely describes the entity you are enrolling. – Select the option from the dropdown list.

***Choose the option that most closely describes the entity you are enrolling**

Corporation
Hospital-Based Physician
Individual Provider
Limited Liability Company
Non-Profit
Sole Proprietorship

OPR Enrollment Type

Please Answer all required questions that are marked with a (*) red asterisk. The following instructions are designed to clarify certain questions. No instructions have been given for questions considered to be self-explanatory.

Provider Enrollment: Provider Identification	
Welcome	* Indicates a required field.
Request Information	Provider Legal Name
Specialties	The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9, and is used by the Nevada Medicaid to generate the annual 1099 form for tax purposes.
Addresses	
Provider Identification	
Managing Individuals	*Last Name <input type="text"/>
Agreement	*First Name <input type="text"/>
Attachments	Middle <input type="text"/>
Summary	Doing Business As Name <input type="text"/>
	Individual Providers
	Gender <input type="text"/> Birth Date <input type="text"/>
	NPI
	The NPI is the National Provider Identifier that is applied for and received through the NPPES Registry for all healthcare providers.
	*NPI <input type="text"/>
	License
	*Name of Issuing Licensing Board, State or Entity <input type="text"/>
	*License Number <input type="text"/> *License State <input type="text"/>
	*Effective Date <input type="text"/> *End Date <input type="text"/>
	Drug Enforcement Administration (DEA) Number
	DEA # <input type="text"/>
	Continue Finish Later Cancel

Provider Legal Name:

Provider Enrollment: Provider Identification	
Welcome	* Indicates a required field.
Request Information	Provider Legal Name
Specialties	The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9, and is used by the Nevada Medicaid to generate the annual 1099 form for tax purposes.
Addresses	
Provider Identification	1. Last Name <input type="text"/>
Managing Individuals	2. First Name <input type="text"/>
Agreement	3. Middle <input type="text"/>
Attachments	4. Doing Business As Name <input type="text"/>
Summary	

1. Last Name – Enter the provider’s last name.
2. First Name – Enter the provider’s first name.
3. Middle Initial – Enter the provider’s middle initial. (Optional)

The provider’s name listed must match the information registered with the Internal Revenue Service (IRS), what is listed on your IRS Employer ID Number (EIN) confirmation letter and the W-9 form. Include a copy of the IRS acceptance letter with the enrollment application.

4. Doing Business as Name – Enter the Doing Business as Name. (Optional)

After all information has been entered on the Provider Information panel for your Enrollment Type:

Click **“Continue”** to continue the enrollment process. – OR –
Click **“Finish Later”** to save the enrollment application and finish it at a later date.
– OR –
Click **“Cancel”** to cancel the enrollment application.

2.5. Associated Providers

This panel will only appear for online provider enrollment applications with a Group Enrollment type, and Provider Types 14, 20, 21, 22, 24, 25, 26, 34, 36, 72, 74, 76, 77 or 82.

To be affiliated with a group the providers must be enrolled with Nevada Medicaid or have already submitted their enrollment application. Signatures are required for each individual being linked to the group. You can upload the signature PDF as part of your online provider enrollment application.


Add the NPIs and individual names or business names of all providers to be affiliated with this group. Click the **"Add"** button to add the NPI and individual name or business name to the grid.

Provider Enrollment: Associated Providers

[Welcome](#)
[Request Information](#)
[Specialties](#)
[Addresses](#)
[Provider Identification](#)
Associated Providers
EFT Enrollment
Other Information
Managing Individuals
Agreement
Attachments
Summary

Select Add to add one or more associated individual providers to the group.

Providers affiliated with the group must be individual provider enrolled in the Nevada Medicaid program or have an application in process. The following form must be completed, including signature(s) and date(s) and uploaded to this application using the Attachments page before being submitted. All documents must be uploaded at the time of provider enrollment form submission in order for your application to be processed and considered complete.

Associated Provider Signature Form [Download](#) 

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click the **Remove** link to remove the entire row.

NPI	Provider Name	Action
<input type="checkbox"/> Click to add Associated Provider.		
Associated Provider National Provider Identifier		
*NPI <input type="text"/>		
Associated Provider Individual Name.		
If the associated provider is an individual, enter their last name, first name and middle initial.		
Last Name <input type="text"/>		
First Name <input type="text"/>		
Middle <input type="text"/>		
Associated Provider Business Name		
If the associated provider is a business, enter the business name.		
Business Name <input type="text"/>		
<input type="button" value="Add"/> <input type="button" value="Cancel"/>		

2.6. EFT

All providers must accept Nevada Medicaid and Nevada Check Up payments via Electronic Funds Transfer (EFT). If a provider does not have an active EFT account enrolled with Nevada Medicaid, that provider's Nevada Medicaid enrollment may be terminated. Note: The EFT page is not displayed for provider types 38, 47, 51, 52, 78, 79 and 60. Individual Providers that are linking to a group and State Agencies will need to answer "Yes" or "No" to the following question:

- Will you only be receiving payment through the Group NPI listed on the Request Information panel that is already enrolled in EFT, or is this application for a state agency?

If the answer is "No", the required Financial Institution Information needs to be completed.

Provider Enrollment: EFT Information	
Welcome	<p>All providers must accept Nevada Medicaid and Nevada Check Up payments via Electronic Funds Transfer (EFT). If a provider does not have an active EFT account enrolled with Nevada Medicaid, that provider's Nevada Medicaid enrollment may be terminated or denied.</p> <p>Electronic Funds Transfer (EFT) Authorization: I hereby authorize Hewlett Packard Enterprise and its subsidiaries to transfer my Nevada Medicaid and Nevada Check Up payments to the personal or business bank account shown below. I also authorize any necessary debit entries to correct payment errors. I understand the payments made through electronic funds transfers will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. This agreement will remain in effect until I notify Hewlett Packard Enterprise or the banking institution otherwise. I understand that Hewlett Packard Enterprise and/or my banking institution may also cancel this agreement at any time. All such cancellation notices must be made in writing and acted upon in a reasonable and timely manner.</p> <p>If you have questions about completing the Electronic Funds Transfer Agreement, contact the Provider Enrollment Unit. If you have questions regarding your payment or the EFT program in general, contact the Customer Service Center. Both Hewlett Packard Enterprise departments may be contacted by phone at (877) 638-3472.</p> <p>You will need to attach a voided check, or a letter from your bank that contains your bank's routing number.</p> <p>Will you only be receiving payment through the Group NPI listed on the Request Information panel that is already enrolled in EFT, or is this application for a state agency? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>Financial Institution Information</p> <p>*Financial Institution Routing Number <input type="text"/></p> <p>*Provider's Account Number with Financial Institution <input type="text"/></p> <p>Reason For Submission New Enrollment</p> <p>Include with Enrollment Submission <input type="text"/></p> <p>Requested EFT Start/Change/Cancel date 11/10/2015</p> <p>Continue Finish Later Cancel</p>
Request Information	
Specialties	
Addresses	
Provider Identification	
EFT Enrollment	
Other Information	
Managing Individuals	
Agreement	
Attachments	
Summary	

If the answer is “Yes,” the Financial Institution Information will not be displayed and does not need to be completed.

Provider Enrollment: EFT Information	
Welcome	
Request Information	All providers must accept Nevada Medicaid and Nevada Check Up payments via Electronic Funds Transfer (EFT). If a provider does not have an active EFT account enrolled with Nevada Medicaid, that provider's Nevada Medicaid enrollment may be terminated or denied.
Specialties	
Addresses	
Provider Identification	
EFT Enrollment	Electronic Funds Transfer (EFT) Authorization: I hereby authorize Hewlett Packard Enterprise and its subsidiaries to transfer my Nevada Medicaid and Nevada Check Up payments to the personal or business bank account shown below. I also authorize any necessary debit entries to correct payment errors. I understand the payments made through electronic funds transfers will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. This agreement will remain in effect until I notify Hewlett Packard Enterprise or the banking institution otherwise. I understand that Hewlett Packard Enterprise and/or my banking institution may also cancel this agreement at any time. All such cancellation notices must be made in writing and acted upon in a reasonable and timely manner.
Other Information	If you have questions about completing the Electronic Funds Transfer Agreement, contact the Provider Enrollment Unit. If you have questions regarding your payment or the EFT program in general, contact the Customer Service Center. Both Hewlett Packard Enterprise departments may be contacted by phone at (877) 638-3472.
Managing Individuals	
Agreement	You will need to attach a voided check, or a letter from your bank that contains your bank's routing number.
Attachments	
Summary	Will you only be receiving payment through the Group NPI listed on the Request Information panel that is already enrolled in EFT, or is this application for a state agency? <input checked="" type="radio"/> Yes <input type="radio"/> No
	<div>Continue Finish Later Cancel</div>

2.7. Other Information

Other Information page displays questions and fields that are specific to the Enrollment Type. The Other Information page will not display for OPR Enrollment Type.

Group Enrollment Type

Provide other additional information, such as Days and Hours of Operation, Accepting New Patients, and number of Medicaid-eligible or certified/licensed beds.

Provider Enrollment: Other Information	
Welcome	Additional information is provided for each enrollment, for group/facility and individual providers.
Request Information	* Indicates a required field.
Specialties	Additional Information
Addresses	*Are you enrolled in Medicare? <input type="radio"/> No <input type="radio"/> Yes
Provider Identification	*Days and Hours of Operation <input type="text"/>
Associated Providers	*Do you currently or will you provide service to recipients in the Fee For Service program, the Managed Careprogram or both? <input type="text"/>
EFT Enrollment	Are you currently accepting new patients? <input checked="" type="radio"/> No <input type="radio"/> Yes
Other Information	*Can you accommodate recipients with special needs? <input checked="" type="radio"/> No <input type="radio"/> Yes
Managing Individuals	Subsidiary or Parent
Agreement	Is the entity a subsidiary or parent of another entity? <input type="radio"/> No <input type="radio"/> Yes
Attachments	Facility Rating
Summary	*Facility Rating <input type="text"/>
	Facility Control
	*Facility Control <input type="text"/>
	Number of Beds
	Swing Bed <input type="text"/> Acute <input type="text"/> ICF <input type="text"/> SNF <input type="text"/> ICF/MR <input type="text"/> ISO <input type="text"/>
	Mamography Certification Number (FDA-Certified mammography providers only)
	Mamography Certification Number <input type="text"/>
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>

Answer all required questions then:

Click **"Continue"** to continue the enrollment process. -- OR --

Click **"Finish Later"** to save the enrollment application and finish it at a later date.

-- OR --

Click **"Cancel"** to cancel the enrollment application.

Individual Enrollment Type

Provide other additional information, such as Days and Hours of Operation, Accepting New Patients, and hospital privileges.

Provider Enrollment: Other Information	
Welcome	Additional information is provided for each enrollment, for group/facility and individual providers.
Request Information	* Indicates a required field.
Specialties	Additional Information
Addresses	
Provider Identification	*Are you enrolled in Medicare? <input type="radio"/> No <input type="radio"/> Yes
EFT Enrollment	*Days and Hours of Operation <input type="text"/>
Other Information	*Do you currently or will you provide service to recipients in the Fee For Service program, the Managed Careprogram or both? <input type="text"/>
Managing Individuals	
Agreement	Are you currently accepting new patients? <input checked="" type="radio"/> No <input type="radio"/> Yes
Attachments	*Can you accommodate recipients with special needs? <input checked="" type="radio"/> No <input type="radio"/> Yes
Summary	Hospital Information
	*Do you have hospital privileges? <input type="radio"/> No <input checked="" type="radio"/> Yes
	*Please describe where? <input type="text"/>
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>

Answer all required questions then:

Click **"Continue"** to continue the enrollment process. -- OR --

Click **"Finish Later"** to save the enrollment application and finish it at a later date.

-- OR --

Click **"Cancel"** to cancel the enrollment application.

2.8. Managing Individuals

Completion of this section is a condition of participation in the Nevada Medicaid program and is mandated by 42CFR §455.100 – 106.

Provide the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health-related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: If A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Other definitions:

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who

directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX of the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

- a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- f) Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor means:

- a) An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- b) An individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmaceutical firm).

Group applications are required to enter all board member(s) if applicable.

This is not required for:

- Individuals linking to group
- Provider Type 38
- Groups and individuals with a Special Ownership type value of Government or State owned selected on the Provider Identification panel

To add a Type of Entity:

Type of Entity Information					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
Click to add Type of Entity.					
*Type of Entity <input type="text"/>					
Corporation Name <input type="text"/>					
Last Name <input type="text"/>					
First Name <input type="text"/>					
Middle <input type="text"/> Birth Date <input type="text"/>					
SSN <input type="text"/> Federal Tax ID <input type="text"/>					
Street <input type="text"/>					
<input type="text"/>					
City <input type="text"/>					
State <input type="text"/> Zip+4 <input type="text"/>					
% of Ownership <input type="text"/>					
Employee Indicator <input type="text"/>					
Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?					
* <input type="radio"/> Yes <input checked="" type="radio"/> No					
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					

1. Entity Type – Select the appropriate type of entity from the drop-down list.

***Type of Entity**

Corporation Name

Last Name

Board Members
Corporation
Managing Employees and/or Agent
Owners

Note: The required fields will vary based on the Type of Entity that is selected.

2. Complete all of the required fields and then click **"Add"** button to add the Type of Entity to the Type of Entity list.

Required fields for Type of Entity Board Member:

Type of Entity Information					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
Click to add Type of Entity.					
<p>*Type of Entity Board Members</p> <p>*Last Name</p> <p>*First Name</p> <p>Middle *Birth Date</p> <p>*SSN</p> <p>*Street</p> <p>*City</p> <p>*State *Zip+4</p> <p>% of Ownership</p> <p>Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?</p> <p><input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>Add Cancel</p>					

Required fields for Type of Entity Corporation:

Type of Entity Information					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
Click to add Type of Entity.					
<p>*Type of Entity Corporation</p> <p>*Corporation Name</p> <p>*Federal Tax ID</p> <p>*Street</p> <p>*City</p> <p>*State *Zip+4</p> <p>*% of Ownership</p> <p>Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?</p> <p><input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>Add Cancel</p>					

Required fields for Type of Entity Managing Employees and/or Agent.

Type of Entity Information					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
<div> <div></div> <div>Click to add Type of Entity.</div> </div>					
<div> <div>*Type of Entity</div> <div>Managing Employees and/or Agent</div> </div>					
<div> <div>*Last Name</div> <div></div> </div>					
<div> <div>*First Name</div> <div></div> </div>					
<div> <div>Middle</div> <div></div> </div>					
<div> <div>*Birth Date</div> <div></div> </div>					
<div> <div>*SSN</div> <div></div> </div>					
<div> <div>*Street</div> <div></div> </div>					
<div> <div></div> <div></div> </div>					
<div> <div>*City</div> <div></div> </div>					
<div> <div>*State</div> <div></div> </div>					
<div> <div>*Zip+4</div> <div></div> </div>					
<div> <div>*Employee Indicator</div> <div></div> </div>					
<div> <div>Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?</div> <div> <div>* Yes</div> <div>No</div> </div> </div>					
<div> <div>Add</div> <div>Cancel</div> </div>					




Required fields for Type of Entity Owner.

Type of Entity Information					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
<div> <div></div> <div>Click to add Type of Entity.</div> </div>					
<div> <div>*Type of Entity</div> <div>Owners</div> </div>					
<div> <div>*Last Name</div> <div></div> </div>					
<div> <div>*First Name</div> <div></div> </div>					
<div> <div>Middle</div> <div></div> </div>					
<div> <div>*Birth Date</div> <div></div> </div>					
<div> <div>*SSN</div> <div></div> </div>					
<div> <div>*Street</div> <div></div> </div>					
<div> <div></div> <div></div> </div>					
<div> <div>*City</div> <div></div> </div>					
<div> <div>*State</div> <div></div> </div>					
<div> <div>*Zip+4</div> <div></div> </div>					
<div> <div>*% of Ownership</div> <div></div> </div>					
<div> <div>Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?</div> <div> <div>* Yes</div> <div>No</div> </div> </div>					
<div> <div>Add</div> <div>Cancel</div> </div>					

If after adding all of the owners and/or corporations the ownership totals less than 100% you are required to provide an explanation in the explanation box provided.

You must also click the "I Agree" checkbox to certify that the application contains information for each person having direct or indirect ownership interest or controlling interest in the disclosing entity and for any subcontracting company in which the disclosing entity has direct or indirect ownership interest of 5 percent or more.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "**Remove**" link to remove the entire row.

Type of Entity Information					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
 1	Owner	Mike Jones	123456789	92	Remove
 2	Managing Employee	Sandy Smith	123456789	N/A	Remove
	Click to add Type of Entity.				

***Explanation if total ownership less than 100%**

There are two additional two that own 4 percent each.

This application contains information for each person having direct or indirect ownership interest or controlling interest in the disclosing entity and for any subcontracting company in which the disclosing entity has direct or indirect ownership interest of 5 percent or more.

***I Agree** ☒

Background and Disclosure of Disclosing Entity

Answer all of the required questions.

Background and Disclosure of Disclosing Entity		
These questions capture information regarding final adverse legal actions, such as convictions, exclusions, revocations and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.		
Who is authorized to make changes to enrollment and billing information?		
Change Authorization Information		
#	Legal Name	Action
<input type="checkbox"/> Click to add Change Authorizations.		
*Last Name <input type="text"/>		
*First Name <input type="text"/>		
<input type="button" value="Add"/> <input type="button" value="Cancel"/>		
Are you or any owner, agent, managing employee, or person with controlling interest currently enrolled, or have ever been enrolled, as a Medicare or Medicaid provider with another state (including Nevada)?		
* <input type="radio"/> Yes <input type="radio"/> No		
Do you or any owner, agent, managing employee or person with controlling interest currently have a negative balance or owe money to any state or federal program (including Medicare and Medicaid)?		
* <input type="radio"/> Yes <input type="radio"/> No		
Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever been convicted of a misdemeanor, gross misdemeanor or felony, including but not limited to, criminal offenses related to any program under Medicare, Title XVIII, Title XIX or any Medicaid program since the inception of these programs?		
* <input type="radio"/> Yes <input type="radio"/> No		
Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever been placed on the Federal Office of Inspector General, Health and Human Service (OIG/HHS) exclusion list or otherwise been suspended, terminated, denied or debarred from participation in any program established under Medicare, Medicaid, Title XVIII, Title XIX or any other Medicaid program since the inception of these programs? This includes termination from the Nevada Medicaid program or any other state Medicaid program.		
* <input type="radio"/> Yes <input type="radio"/> No		
Are you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest currently under investigation by any law enforcement, regulatory or state agency?		
* <input type="radio"/> Yes <input type="radio"/> No		
Do you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest have any open or pending court cases?		
* <input type="radio"/> Yes <input type="radio"/> No		
Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever been denied malpractice insurance?		
* <input type="radio"/> Yes <input type="radio"/> No		
Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked?		
* <input type="radio"/> Yes <input type="radio"/> No		
Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever voluntarily surrendered any professional license or certificate?		
* <input type="radio"/> Yes <input type="radio"/> No		
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>		

Click **"Continue"** to continue the enrollment process. – OR –

Click **"Finish Later"** to save the enrollment application and finish it at a later date.

– OR –





Click **"Cancel"** to cancel the enrollment application.

2.9. Agreements

You must accept the terms outlined in the Agreements page in order to submit the online provider enrollment application. Failure to accept these terms mean that the request will not be submitted or saved.

Changes can be made to the existing request by going back to the appropriate screen using the links available on the left-hand side of the application. Once changes are made, the request can be reviewed from the Summary Page.

Note: The Nevada Medicaid and Nevada Check Up Provider Contract and Provider Declaration Statement are required with every request. A link to these documents is provided on the Agreements page.

Provider Enrollment: Agreement ?	
Welcome Request Information Specialties Addresses Provider Identification Associated Providers EFT Enrollment Other Information Managing Individuals Agreement Attachments Summary	<div> Instructions <p>The terms of the request are outlined below. You must accept these terms in order to submit the request. Failure to accept these terms mean that the request will not be submitted or saved.</p> <p>Changes can be made to the existing request by going back to the appropriate screen using the links available on the left-hand side. Once changes are made, the request can be reviewed from the Summary Page after signing and continuing.</p> <p>Once the request is submitted and confirmed, a tracking number will be assigned.</p> <p>Note: The Nevada Medicaid and Nevada Check Up Provider Contract and Provider Declaration Statement are required with every request. A link to these documents is provided below.</p> </div> <div> Terms of Agreement <p>Provider Name</p> <p>Street</p> <p>Employer Identification Number (EIN) or Social Security Number (SSN)</p> <p>NPI</p> <p>Contact Name</p> <p>Contact Email</p> </div> <div> Provider Binder <p>I certify, under penalty of perjury, that the information and statements on this request and on any accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this request is sufficient cause for denial of enrollment or termination from the Nevada Medicaid and Nevada Check Up Programs.</p> <p>I understand that should I be enrolled as a provider of services under Nevada Medicaid and Nevada Check Up Programs, this it is my responsibility to notify the Nevada Medicaid and Nevada Check Up Programs fiscal agent of any change to the information on this application including but not limited to address, group affiliation, change of ownership, or tax identification number.</p> </div> <div> Forms <p>The following forms must be completed, including signature and date(s) and uploaded to this application using the Attachments page before being submitted. All documents must be uploaded at the time of provider enrollment form submission in order for your application to be processed and considered complete.</p> <p>Provider Declaration Statement Download </p> <p>Nevada Medicaid and Nevada Check Up Provider Contract Download </p> <p>EFT Authorization Download </p> <p></p> </div> <div> Continue Finish Later Cancel </div>

2.10. Attachments

Submit all of the required documentation and forms to continue the request.

A checklist of required documentation can be found here:

(<https://www.medicaid.nv.gov/providers/checklist.aspx>).

In addition to required documentation, additional supporting documentation can be uploaded with your application if necessary. If your responses to any questions on this enrollment application did not fit into the field on the page, type the question and response and upload the documentation using Other as the attachment type.

All documents must be uploaded at the time of the online provider enrollment submission in order for your application to be considered complete.

[Welcome](#)
[Request Information](#)
[Specialties](#)
[Addresses](#)
[Provider Identification](#)
[Associated Providers](#)
[EFT Enrollment](#)
[Other Information](#)
[Managing Individuals](#)
[Agreement](#)
▶ Attachments
[Summary](#)

Provider Enrollment: Attachments

Supporting Documentation

Submit all of the required documentation and forms to continue the request.

- A checklist of required documentation can be found [here](#).

In addition to required documentation, additional supporting documentation can be uploaded with your application if necessary. If your responses to any questions on this enrollment application did not fit into the field on the page, type the question and response and upload the documentation using Other as the attachment type. All documents must be uploaded at the time of provider enrollment forms submission in order for your application to be considered complete. To upload the appropriate documents, follow the instructions under **Attachments** below.

Note: There is a maximum of 15 MBs of information when uploading attachments by **File Transfer**.

* Indicates a required field.

Provider Type and Specialty

Provider Type

Provider Specialty

Attachments

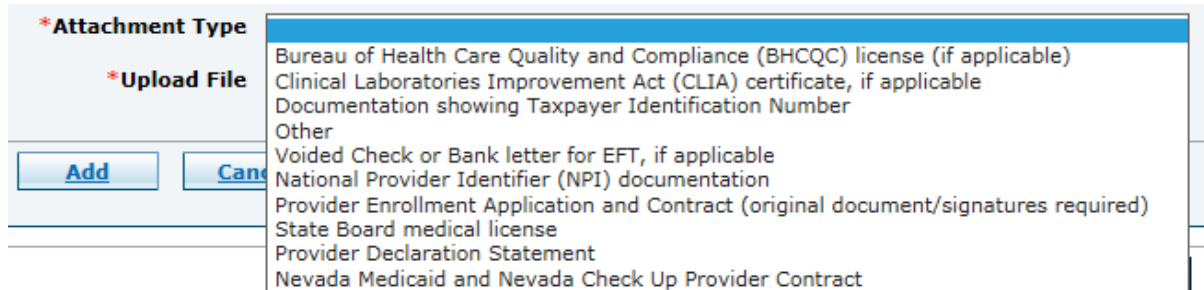
To add an attachment to be uploaded with the enrollment form, select the File Transfer transmission type, click Browse..., select the file and then click **Add**.
Only allowed attachment types are .pdf files.
Use the "Other" attachment type to upload attachments not in the list.

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action
<input type="checkbox"/> Click to collapse.				
<div><div>*Transmission Method</div><div>FT-File Transfer ▼</div><div>*Attachment Type</div><div>▼</div><div>*Upload File</div><div><div>Browse...</div></div><div><div>Add</div><div>Cancel</div></div></div>				
<div><div>Continue</div><div>Finish Later</div><div>Cancel</div></div>				

To add an attachment to be uploaded with the online provider enrollment application:

1. Transmission Method - Select FT-File Transfer.
2. Attachment Type – Select the type of file that is going to be uploaded from the drop down list.



The screenshot shows a web form interface. On the left, there is a section titled "*Attachment Type" with a sub-label "*Upload File". Below this are two buttons: "Add" and "Cancel". To the right of the "Add" button is a dropdown menu that is currently open, displaying a list of attachment types. The list includes: Bureau of Health Care Quality and Compliance (BHCQC) license (if applicable), Clinical Laboratories Improvement Act (CLIA) certificate, if applicable, Documentation showing Taxpayer Identification Number, Other, Voided Check or Bank letter for EFT, if applicable, National Provider Identifier (NPI) documentation, Provider Enrollment Application and Contract (original document/signatures required), State Board medical license, Provider Declaration Statement, and Nevada Medicaid and Nevada Check Up Provider Contract.

*Attachment Type
Bureau of Health Care Quality and Compliance (BHCQC) license (if applicable)
Clinical Laboratories Improvement Act (CLIA) certificate, if applicable
Documentation showing Taxpayer Identification Number
Other
Voided Check or Bank letter for EFT, if applicable
National Provider Identifier (NPI) documentation
Provider Enrollment Application and Contract (original document/signatures required)
State Board medical license
Provider Declaration Statement
Nevada Medicaid and Nevada Check Up Provider Contract

3. Upload File – Click the "Browse" button and select the file from your computer. The only allowable file types are PDF documents (.pdf).
4. Click the "Add" button.
5. Repeat steps 1 through 4 to add additional documents to the online provider enrollment application.

Note: There is a maximum of 15MBs of information when uploading attachments.

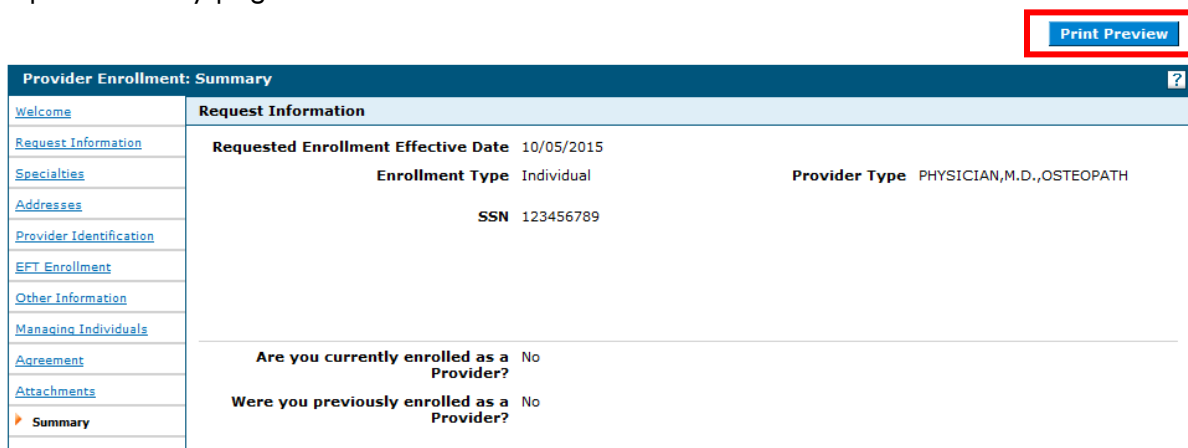
2.11. Summary

The summary page provides a summary of all of the information that was included on the provider enrollment application.

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields.

You can print a copy of the summary for your records. Select "Print Preview" at the top or bottom of the Summary page.

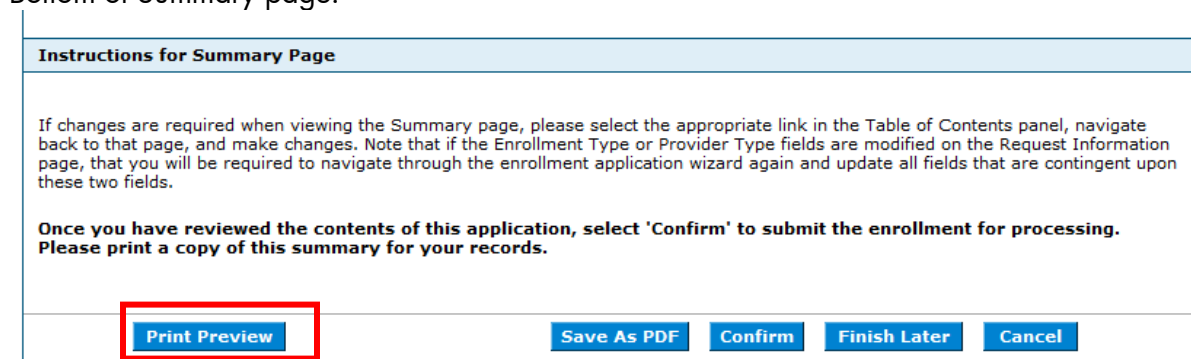
Top of Summary page.



Provider Enrollment: Summary ?

Welcome	Request Information
Request Information	Requested Enrollment Effective Date 10/05/2015
Specialties	Enrollment Type Individual Provider Type PHYSICIAN,M.D.,OSTEOPATH
Addresses	SSN 123456789
Provider Identification	
EFT Enrollment	
Other Information	
Managing Individuals	
Agreement	Are you currently enrolled as a Provider? No
Attachments	Were you previously enrolled as a Provider? No
Summary	

Bottom of Summary page.



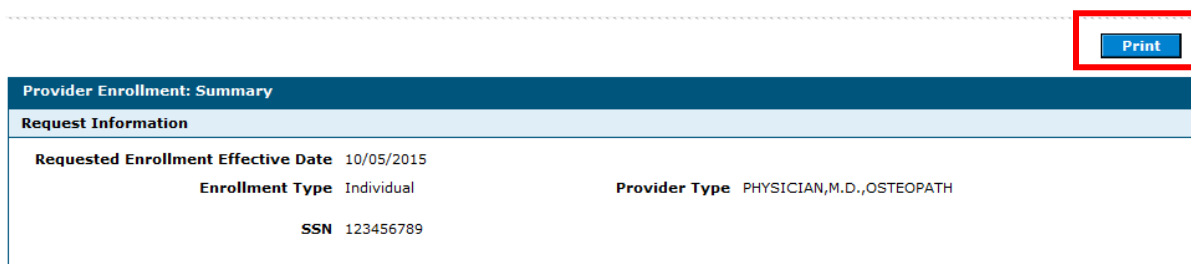
Instructions for Summary Page

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields.

Once you have reviewed the contents of this application, select 'Confirm' to submit the enrollment for processing. Please print a copy of this summary for your records.

[Print Preview](#) [Save As PDF](#) [Confirm](#) [Finish Later](#) [Cancel](#)

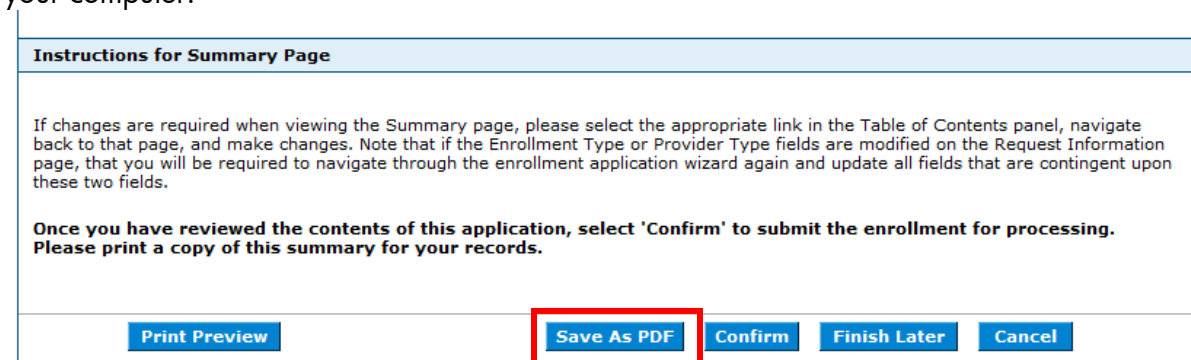
After you click Print Preview a new window opens; click “Print” to print the Summary page.



The screenshot shows the 'Provider Enrollment: Summary' page. At the top right, there is a blue button labeled 'Print' which is highlighted with a red rectangle. Below this is a section titled 'Request Information' containing the following details:

Requested Enrollment Effective Date	10/05/2015
Enrollment Type	Individual
Provider Type	PHYSICIAN,M.D.,OSTEOPATH
SSN	123456789

You can save a copy of the summary as a PDF. Select “Save As PDF” and then save to your computer.



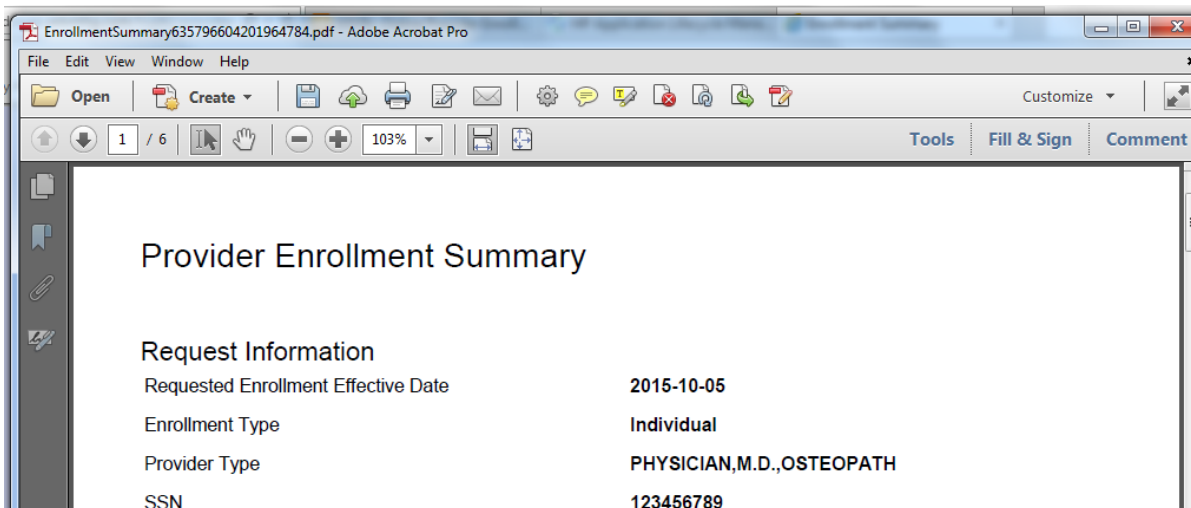
The screenshot shows the 'Instructions for Summary Page' section. It contains the following text:

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields.

Once you have reviewed the contents of this application, select 'Confirm' to submit the enrollment for processing. Please print a copy of this summary for your records.

At the bottom of the page, there are five buttons: 'Print Preview', 'Save As PDF' (highlighted with a red rectangle), 'Confirm', 'Finish Later', and 'Cancel'.

After you click “Save As PDF,” a new window opens and displays the PDF and you can save the PDF to your computer.



The screenshot shows the Adobe Acrobat Pro window displaying the 'Provider Enrollment Summary' PDF. The window title is 'EnrollmentSummary635796604201964784.pdf - Adobe Acrobat Pro'. The PDF content is as follows:


Provider Enrollment Summary	
Request Information	
Requested Enrollment Effective Date	2015-10-05
Enrollment Type	Individual
Provider Type	PHYSICIAN,M.D.,OSTEOPATH
SSN	123456789

Once you have reviewed the contents of the application, select “Confirm” to submit the enrollment for processing.


Instructions for Summary Page	
<p>If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields.</p> <p>Once you have reviewed the contents of this application, select 'Confirm' to submit the enrollment for processing. Please print a copy of this summary for your records.</p>	
Print Preview	Save As PDF Confirm Finish Later Cancel

2.12. FAQs

The Online Provider Enrollment home page has a link to Frequently Asked Questions regarding the online provider enrollment application. You can click this link to see a list of frequently asked questions and answers.



Nevada Department of Health and Human Services
 Division of Health Care Financing and Policy Provider Portal


[Contact Us](#)
[Frequently Asked Questions](#)

Provider Enrollment

Provider Enrollment

[Provider Enrollment Application](#)
 Initiate a new provider enrollment application.

[Resume Enrollment](#)
 Resume an existing enrollment application that has not been submitted.

[Enrollment Status](#)
 Check the current status of an enrollment application.

Other Links

[Division of Health Care Financing and Policy](#)
[Provider Enrollment Information Booklet](#)
[Enrollment Checklist](#)